New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0157C	A. BUILDING _____ B. WING _____	03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - SCHENECTADY	650 FRANKLIN STREET, SUITE 102 SCHENECTADY, NY 12305

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H 000	Initial Comments A full licensure survey was conducted on March 30 and 31, 2010 to evaluate the agency's compliance with state regulations. The survey consisted of a review of the agency's Quality Assurance activities, complaint log, selected policies and procedures, health provider network, eight patient records, three which included Home and Community Support Services (HCSS) and six personnel records. Complaints # NY00083929 and #NY00081568 was also investigated during the survey. Three home visits were made, one was a HCSS patient. The agency Vice President (VP), Branch Manager and the Director of Patient Services (DPS) were interviewed. The findings were discussed with the VP, Branch Manager and DPS at the exit conference on 3/31/10. The following deficiencies are being cited as a result of the survey.	H 000		
H 512	766.4(c) Medical Orders 766.4 Medical orders. ..... (c) Such orders shall be reviewed and revised as the needs of the patient dictate but no less frequently than every six months, except where an authorized practitioner, as part of an authorization, orders personal care services for up to one year for a Medicaid patient This Regulation is not met as evidenced by: Based on review of eight patient records and staff interview this requirement is not met. There is no evidence in three of eight records (patients # 1, 2 and 6) that the agency reviewed and revised the patient's physician orders at least every six months. Failure to review and revise the physician orders	H 512		

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H 512	Continued From page 1 every six months may lead to unmet patient needs and possible negative patient outcomes. Findings: Patient # 1 was admitted 12/28/09 with diagnoses Cerebral Vascular Accident and hypertension. The physician orders are for the period 12/28/09 to 2/26/10. There is no documented evidence in the patient record that orders were obtained after 2/26/10. Patient # 2 was admitted 3/4/09 with diagnoses of Alzheimer's disease, Myocardial Infarction and hypertension. The physician orders are for the period 8/31/09 to 2/27/10. There is no documented evidence in the patient record that orders were obtained after 2/27/10. On 3/30/10 the findings were reviewed with the Director of Patient Services who agreed with the findings. Patient # 6 was admitted to the agency on 6/19/09 for personal care aide services. There are no signed physician orders in the patient record authorizing patient care services. The above findings were reviewed with the Vice President of Clinical Services, Branch Manager and Director of Patient Services during the exit conference on 3/31/10.	H 512		
H 514	766.4(d) Medical orders 766.4 Medical orders. ..... (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and	H 514		

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H 514	Continued From page 2 (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Regulation is not met as evidenced by: Based on review of eight patient records and staff interview this requirement was not met. Six of eight records (#1, 2, 4, 5, 7 and 8) contained physician orders that were inconsistent with information documented in patient record. Additionally, physician orders were not obtained when changes in the patient's status indicated. While no negative outcome was identified this has potential to result in patient harm as a consequence of the patient not receiving the correct services, treatments and medications. Findings: Patient #1 was admitted 12/28/09 with diagnoses Cerebral Vascular Accident and hypertension. The physician's order dated 12/28/2009-2/26/10 documents HCSS (home and community support services) for oversight and supervision 4 hours daily 7 days a week, 2-5 hours on weekends, with floating hours. In reviewing the employee time and aide activity sheets for the time frame 12/29/09 through 2/28/10 (76 days), there were a total of 42 days that the patient did not receive the ordered services. There is no documented evidence in the patient's record as to why service was not provided or that the physician/patient was notified. Patient # 2 was admitted 3/4/09 with diagnoses of	H 514		

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H 514	Continued From page 3 Alzheimer's disease, Myocardial Infarction and hypertension. The physician orders for the periods 3/4/09 to 8/31/09 and 8/31/09 to 2/27/10. There is no documented evidence in the patient's record that orders were obtained after 2/27/10. On 3/30/10 the findings were reviewed with the Director of Patient Services who agreed with the findings. The "aide care plan" dated 3/4/09 and updated 8/12/09 reveals that the PCA and HHA are both checked. It is unclear on what type of aide service this patient is receiving. Review of the employee time and aide activity sheet reveals the patient did not receive an aide on the following dates 12/5, 15, 16, 17, 18, 25/09 and 1/1/2010. There is no documented evidence in the patient's record as to why service was not provided or that the physician/patient was notified. Patient #4 was admitted 3/3/08 with diagnoses of hypertension, urinary incontinence and dementia. The physician ' s order dated 2/17/10 - 8/16/10 was not signed at the time of the survey. The physician's order dated 2/17/10 - 8/16/10 documents under medications Aspirin 81 mg daily po (by mouth), Calcium/vitamin D 600/400 meals po, Niacin 1000mg daily po, Vitamin D3 1000mg 2 daily po and Furosemide (Lasix) 20mg tab daily po. The first 4 medications are not listed on the medication profile and furosemide is listed as 40mg daily. Patient # 5 was admitted on 11/13/02 with diagnoses Trisomy 7 (a genetic disorder with multiple anomalies), reactive airway disease and gastro esophageal reflux. The patient receives licensed practical nursing (LPN) services 10 hours a day, overnight and 8.5 hours during the day, five days a week. The physician orders for	H 514		

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H 514	Continued From page 4 the periods 11/17/09 to 1/16/10 and 1/16/10 to 3/17/10 were reviewed. The orders document "bilateral leg braces as tolerated". There is no further documentation in regard to the use the leg braces. The nurse documents on the "Medication Administration Record" dated December 2009, O2 (oxygen) 1 to 2 liters as needed to maintain oxygen saturations at 95% or greater. There is no physician's order for the oxygen from 11/17/09 to 1/16/10. Additionally, the nurse documents on the "Medication Administration Record" administration of Amox TR-K CIV 400-57/5 suspension 5mls (milliliters) two times a day (BID) times for 10 days. The nurse documents administration of the Amox TR-K-CIV two times a day from 12/4-12/8 and 12/10/09. There is no documented evidence a physician's order was obtained for Amox TR-K-CIV. On the clinical nursing note dated 2/20/10 the LPN documents patient "to start prednisolone for 5 days, All Metro informed of change". The medication administration record dated February 2010 lists 2/25 Prednisolone 15 mg (milligrams)/5ml, give 3 teaspoons (tsp) day one, 2 tsp for two days and 1 tsp for two days. The nurse documents administration of the medication on 2/25 and 2/26 and 3/1. There is no documented evidence the physician was contacted for this order. Patient #7 was admitted on 10/27/09 with diagnoses rheumatoid arthritis and anemia. The physician orders for the period 10/27/09 to 4/25/10 under medications list the following: Tramadol HCL, used for pain, 50mg every 8 hours by mouth (po) as needed, Hydrocodone APAP, used for pain, 5/500, po every 6 hours as needed, Prednisone 5mg, 2, po daily, Iron glycinate 28mg, po, three times a day.	H 514		

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H 514	Continued From page 5 The medication profile dated 10/27/09 list the same medications with different dosages as follows: Tramadol HCL 37.5/325mg, 1 to 2 tablets 2-3 times a day po for pain, Hydrocodone APAP, 7.5/750, one every 4-6 hours po for pain, Prednisone 5mg, daily, po, Iron 65mg, daily, po. The record lacks evidence the physician was contacted to clarify the correct dosage of these medications. Patient #8 was admitted 11/24/09 with diagnoses of Cerebral Vascular Accident and depression. The physician's order dated 11/27/2009-5/26/10 documents under medications Zetia 10mg bid po and isopto tears 1-2gtt (drop) 4-6 hour prn (as needed). The medication profile documents Zetia 10mg daily po and isopto tears 1gtt prn dry eye. The record lacks evidence the physician was contacted to clarify the correct dosage of these medications. The employee time and activity sheets were reviewed from 12/1/09 through 2/15/10, under the weekly note, the PCA documents nine times, assisted the patient with exercise of the left hand. There is no order for exercises of the left hand and doing passive exercises is not within the scope of practice of a PCA. The agency's policy for "Personal Care Aide (PCA)" documents under "Duties and Responsibilities: #9 Reminding the patient to perform prescribed exercises". On 3/31/10 the findings were reviewed with the Director of Patient Services and the Branch Manager both stated this is not in the scope of practice of a PCA. Review of the employee time and activity sheet reveals the patient did not receive an aide on the following dates 12/28, 29, 30, 31/09, 1/1, 2 and 3/2010. There is no documented evidence in the	H 514		

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H 514	Continued From page 6 patient's record as to why service was not provided or that the physician/patient was notified. The above findings were reviewed with the Vice President of Clinical Services, Branch Manager and Director of Patient Services during the exit conference on 3/31/10. No explanation was provided.	H 514		
H 616	766.5(b)(2) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: ..... (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision: ..... (2) staff are assigned to the care of patients in accordance with their licensure, and their training, orientation, and demonstrated skills. This Regulation is not met as evidenced by: Based on review of eight patient records, home visits, review of there policy for "Personal Care Aide" and staff interview this requirement is not met. For three of eight patients (patient #1, 2 and 8) personal care aides (PCA) performed patient care not within their scope of practice/training. Failure to ensure that the PCA provide care in accordance with their training places patients at risk for poor quality care. Patient #1 was admitted 12/28/09 with diagnoses Cerebral Vascular Accident and hypertension. The Personal Care Plan dated 12/28/09 documents "foot soak upon request, exercise nightly and brace on left leg on am off pm". The	H 616		

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H 616	Continued From page 7 aide documents on the employee time and activity sheet for the following dates 12/28, 29, 30, 31/09, 1/1 and 1/8/2010 and 2/1/2010 that a foot soak was done for the patient. On 1/4 and 1/5/10 the aide documents heat pack to back. On 2/15 and 2/16/10 the aide documents "new boot for her left leg. She is getting used to it". There is no evidence in the record that the aide was instructed on how to use the new boot. On 12/28, 29, 30, 31/09, 1/1 and 1/11/10, 3/1, 2, 3, 4 and 10/2010 the aide documents exercises done. On a home visit 3/31/10 the surveyor asked the daughter and patient how the aide helps the patient with her exercises. They both stated that the aide has to actively move her left leg and arm, as the patient cannot due to her stroke. All of the above tasks are not within the scope of practice of a PCA. Patient # 2 was admitted 3/4/09 with diagnoses of Alzheimer ' s disease, Myocardial Infarction and hypertension. The physician's signed interim order dated 5/15/2009 documents "increase PCA hours to 2 hours 5 days a week. The physician ' s order dated 8/31/2009-2/27/10 documents under orders PCA/HHA (home health aide) for up to 2 hours, up to 5 day a week. Additionally the "aide care plan" dated 3/4/09 and updated 8/12/09 reveals that the PCA and HHA are both checked. It is unclear on what type of aide service this patient is receiving. During a home visit by the surveyor on 3/30/10 the patient's wife stated that the aide does PT (physical therapy) exercises for her husband. When asked to see the home exercise program materials the aide and the wife could not locate the information. The patient's wife stated that the aide has been doing these passive exercises since the spring of 2009. The aide also told the	H 616		

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H 616	Continued From page 8 surveyor that the patient had a swallowing evaluation done approximately 2 weeks ago by a speech therapist and she instructed the aide to assist the patient. The aide did show the surveyor the exercise program information that the speech therapist left. The "aide care plan" dated 3/4/09 and updated 8/12/09 does not document PT/speech exercises. There is no documented evidence that an order was obtained for the aide to do exercises. Patient #8 was admitted 11/24/09 with diagnoses of Cerebral Vascular Accident and depression. The employee time and activity sheets were reviewed from 12/1/09 through 2/15/10, under the weekly note, the PCA documents nine times, assisted the patient with exercise of the left hand. There is no order for exercises of the left hand and doing passive exercises is not within the scope of practice of a PCA. The agency's policy for "Personal Care Aide (PCA)" documents under "Duties and Responsibilities: #9 Reminding the patient to perform prescribed exercises". The above findings were reviewed with the Vice President of Clinical Services, Branch Manager and Director of Patient Services during the exit conference on 3/31/10. It was stated this is not in the scope of practice of a PCA. No further explanation was provided.	H 616		

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POC accepted 6/1/10 [redacted]

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H 514	766 4(d) Medical orders 766 4 Medical orders (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care, and		**H514** **766.4(d) Medical Orders** It is all Metro Health Care's policy that all service orders other than 24 hour must- cover orders be written with an acceptable range of hours/days of service, validated by the MD. When a shift is uncovered, the patient/family is to be notified and a note is to be written in the ProHealth system explaining the gap in service. If this *occurs more than once*, the MD is to be notified and the aide(s) are to be changed. If this does not solve the problem, the open hours are to be called out to another agency for coverage. ProHealth notes are to be checked daily by the DCS and if such a problem is identified the above noted process shall be put in place to remedy the situation. Aide time sheets are verified weekly against the schedule as part of the payroll process, and the Payroll Coordinator is to be instructed that gaps are to be reported to the Branch Manager and DCS. An audit of all case managed cases is to be completed for the previous and upcoming month by May 31, 2010, to identify coverage issues and make necessary corrections. All associate staff are to be reoriented to All Metro's policy regarding notifying the patient/family of open shifts and documenting same in the system. A memo *(Exhibit C - attached) was sent* to all nursing supervisors *on 5-7-10* to remind them of the requirement for them to check the aide care plan against the time sheet to assure that the aides are addressing all requirements on the care plan and that they are not documenting care that *is not* on the care plan. Additionally they will be sent a copy of the job description for a HHA and a PCA for their reference when completing Aide Care Plans. If the care of the patient calls for tasks above the level of the service authorized, the office will be notified immediately so that a discussion can be had with the patient and family regarding how to meet the patient's needs while adhering to regulatory requirements.	

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H 514	Continued From page 2 (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Regulation is not met as evidenced by: Based on review of eight patient records and staff interview this requirement was not met. Six of eight records (#1, 2, 4, 5, 7 and 8) contained phytician orders that were inconsistent with information documented in patient record. Additionally, physician orders were not obtained when changes in the patient's status indicated While no negative outcome was identified this has potential to result in patient harm as a consequence of the patient not receiving the correct services, treatments and medications. Findings: Patient #1 was admitted 12/28/09 with diagnoses Cerebral Vascular Accident and hypertension. The physician's order dated 12/28/2009-2/28/10 documents HCSS (home and community support services) for oversight and supervision 4 hours daily 7 days a week, 2-5 hours on weekends, with floating hours. In reviewing the employee time and aide activity sheets for the time frame 12/28/09 through 2/28/10 (76 days), there were a total of 42 days that the patient did not receive the ordered services. There is no documented evidence in the patient's record as to why service was not provided or that the physician/patient was notified. Patient # 2 was admitted 3/4/09 with diagnoses of	H 514	H514 All case managed files are to be reviewed by the DCS to assure that POC's are congruent with Med Profiles and Med Admin Records. Nursing and aide notes are to be reviewed weekly to assure that they are compliant with MD orders. Any variances are to be addressed/corrected immediately, and unclear/incomplete orders are to be clarified by the MD and rewritten accordingly. All medications are to be reviewed by an RN during recertification visits, with POC's/Medication Profiles updated as needed. Orders for treatments and DME are to be clearly written indicating frequency and any other pertinent details. If the aide is to be applying braces or any other device, he/she is to be trained to do so by an RN, the training shall be documented, and the procedure to be clearly outlined on the Aide Care Plan. If a HHA is to perform exercises outlined by a PT/ST, a copy of these exercises shall be in the patient's chart and an order for same shall be validated by an MD. All field staff, including nurses, are to be sent a memo reminding them that they must notify the office immediately of any changes in the patient's status, treatment protocol or medications so that the orders and care plans may be updated accordingly and the changes noted in ProHealth. Interim Orders are to be tracked on the Physicians' Order Log along with all other MD orders. Nursing Supervisors are to review the home chart for all skilled cases during each visit to determine that the MAR's and treatments records are compliant with orders. If a parent is administering a medication, this shall be indicated on the Med. Adm. Record so that all doses are accounted for.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0157C	A. BUILDING _____ B. WING _____	03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - SCHENECTADY	650 FRANKLIN STREET, SUITE 102 SCHENECTADY, NY 12305

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H 514	Continued From page 4 the periods 11/17/09 to 1/16/10 and 1/16/10 to 3/17/10 were reviewed. The orders document "bilateral leg braces as tolerated." There is no further documentation in regard to the use the leg braces. The nurse documents on the "Medication Administration Record" dated December 2009, O2 (oxygen) 1 to 2 liters as needed to maintain oxygen saturations at 95% or greater. There is no physician's order for the oxygen from 11/17/09 to 1/16/10. Additionally, the nurse documents on the "Medication Administration Record" administration of Amox TR-K CIV 400-57/5 suspension 5mls (milliliters) two times a day (BID) times for 10 days. The nurse documents administration of the Amox TR-K-CIV two times a day from 12/4-12/8 and 12/10/09. There is no documented evidence a physician's order was obtained for Amox TR-K-CIV. On the clinical nursing note dated 2/20/10 the LPN documents patient "to start prednisolone for 5 days, All Metro informed of change". The medication administration record dated February 2010 lists 2/25 Prednisolone 15 mg (milligrams)/5ml, give 3 teaspoons (tsp) day one, 2 tsp for two days and 1 tsp for two days. The nurse documents administration of the medication on 2/25 and 2/28 and 3/1. There is no documented evidence the physician was contacted for this order. Patient #7 was admitted on 10/27/09 with diagnoses rheumatoid arthritis and anemia. The physician orders for the period 10/27/09 to 4/25/10 under medications list the following: Tramadol HCL, used for pain, 50mg every 8 hours by mouth (po) as needed, Hydrocodone APAP, used for pain, 5/500, po every 6 hours as needed, Prednisone 5mg, 2, po daily, Iron glycinate 28mg, po, three times a day.	H 514	This shall be monitored during routine, biannual internal audits conducted by the Office of the VP of Patient Services. *All Internal, External and DOH audit results are reviewed with and discussed by the Q.I. Committee (Exhibit B – attached) at the next scheduled Committee Meeting.* Compliance is to be maintained at 90%. **Responsible Individual – DCS and VP of Patient Services** **Completion Date – May 31, 2010**	

New York State Department of Health

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H 514	Continued From page 5 The medication profile dated 10/27/09 list the same medications with different dosages as follows: Tramadol HCL 37 5/325mg, 1 to 2 tablets 2-3 times a day po for pain. Hydrocodone APAP, 7 5/750, one every 4-6 hours po for pain Prednisone 5mg, daily, po. Iron 65mg, daily po The record lacks evidence the physician was contacted to clarify the correct dosage of these medications. Patient #8 was admitted 11/24/09 with diagnoses of Cerebral Vascular Accident and depression. The physician's order dated 11/27/2009-5/26/10 documents under medications Zeba 10mg bid po and isopto tears 1-2gtt (drop) 4-6 hour prn (as needed). The medication profile documents Zeba 10mg daily po and isopto tears 1gtt prn dry eye The record lacks evidence the physician was contacted to clarify the correct dosage of these medications. The employee time and activity sheets were reviewed from 12/1/09 through 2/15/10. under the weekly note, the PCA documents nine times assisted the patient with exercise of the left hand There is no order for exercises of the left hand and doing passive exercises is not within the scope of practice of a PCA The agency's policy for "Personal Care Aide (PCA)" documents under "Duties and Responsibilities: #9 Reminding the patient to perform prescribed exercises" On 3/31/10 the findings were reviewed with the Director of Patient Services and the Branch Manager both stated this is not in the scope of practice of a PCA Review of the employee time and activity sheet reveals the patient did not receive an aide on the following dates 12/28, 29, 30, 31/09, 1/1, 2 and 3/2010. There is no documented evidence in the		**H514 Addendum** **766.4(d) Medical Orders** Patient #1 – Reason for gaps in service noted noted – moving forward, after a second occurrence the MD will be notified and a change of aide will be sought. Failing that, the open hours shall be transferred to another agency. Patient #2 – obtained signed POC on 4/6/10. Patient #4 - POC of 2/17/10 resent to MD, signed, returned and filed. The first four meds on the POC have been added to the Medication Profile and the furosemide order has been clarified by the MD and corrected to read 40mg daily. Patient #5 – MD order for "bilateral leg braces as tolerated." Nursing notes to be reviewed by DCS or RN designee weekly for reference to application/removal of leg braces. This has already begun – 5-11-10. Unable to correct the missing order for O2 from 11/17/09 to 1/16/10 at this late date. Unable to correct the missing order for Amoxicillin in December '09 at this late date. Unable to correct the missing Prednisolone order for 2/25/10 at this late date. Patient #7 – MD has been contacted to clarify the orders for Tramadol HCL, Hydrocodone with APAP, Prednisone and Iron. The correct doses have been validated on an Interim Order and transposed onto the Medication Profile. Patient #8 - MD has been contacted to clarify the orders for Zetia and Isopto tears. The correct doses have been validated on an Interim Order and transposed onto the Medication Profile. Aide has been counseled regarding passive exercises being outside her job description, and that she may only remind a patient to complete their exercises, if such activity is on the Aide Care Plan. **Completion Date – May 31, 2010**	

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H 514	Continued From page 6 patient's record as to why service was not provided or that the physician/patient was notified The above findings were reviewed with the Vice President of Clinical Services, Branch Manager and Director of Patient Services during the exit conference on 3/31/10 No explanation was provided. H 616 766 5(b)(2) Clinical supervision 766.5 Clinical supervision The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised The department shall consider the following factors as evidence of adequate supervision: (2) staff are assigned to the care of patients in accordance with their licensure, and their training, orientation, and demonstrated skills. This Regulation is not met as evidenced by Based on review of eight patient records, home visits, review of there policy for "Personal Care Aide" and staff interview this requirement is not met. For three of eight patients (patient #1, 2 and 8) personal care aides (PCA) performed patient care not within their scope of practice/training. Failure to ensure that the PCA provide care in accordance with their training places patients at risk for poor quality care Patient #1 was admitted 12/28/09 with diagnoses Cerebral Vascular Accident and hypertension. The Personal Care Plan dated 12/28/09 documents "foot soak upon request, exercise nightly and brace on left leg on am off pm" The		**H514 Addendum** **766.4(d) Medical Orders** Patient #1 – the aide documenting foot soaks has been counseled and re-educated to the fact that foot soaks require an MD Rx. She has been properly inserviced by an RN regarding the brace for the patient's ® leg and that she may only remind him to do exercises. Passive exercises are not permitted by a PCA. The Aide Care Plan has been corrected to reflect permissible activities only. **Completion Date – May 31, 2010** Patient #2 – This is a PCA level case and the Aide Care Plan has been corrected to reflect only this level of care. The nursing staff has been reminded that in instances where an exercise program is permissible by a properly trained HHA, that the written exercise plan shall be in the home as well as in the office chart. The aide care plan has been updated to include PT/Speech exercise reminder and the staff doing this case have been reoriented to the updated Aide Care Plan. An Interim MD Rx has been obtained for the PT/speech exercises and will be moving forward for any changes in treatments for all patients. **Completion Date – May 31, 2010** Patient #8 – passive exercises are out of the scope of a PCA. The PCA may only remind the client to do prescribed exercises. An interim order has been sent to the MD and this reminder will be included on the Aide Care Plan, removing any direction for passive exercises. The aide has been counseled and reoriented to her job description and permissible activities. A memo will be sent to all PCA's reminding them that passive exercises are outside their scope, and that they should neither be doing this nor documenting this type of activity. **Completion Date – May 31, 2010**	